		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001628

Facility Name: Monroe County Nursing Home

Address: 500 Illinois (Number) Waterloo (City) 62298 (Zip Code)

County: Monroe

Telephone Number: (618) 939-3488 **Fax #** (618) 939-5030

IDPA ID Number: 376006468001

Date of Initial License for Current Owners: 11/14/1950

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/02 to 11/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,830	1
2		Skilled Pediatric (SNF/PED)			2
3	69	Intermediate (ICF)	69	25,185	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	365	965	4,452	5,782	8
9	SNF/PED					9
10	ICF	31,056	21,180		52,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,421	22,145	4,452	58,018	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.33%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1952

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,785

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 11/30/03 Fiscal Year: 11/30/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	313,555	23,016	11,095	347,666		347,666		347,666			1
2	Food Purchase		191,074		191,074		191,074	(2,054)	189,020			2
3	Housekeeping	209,818	26,177		235,995		235,995		235,995			3
4	Laundry	103,502	20,260		123,762		123,762		123,762			4
5	Heat and Other Utilities			279,077	279,077		279,077	(1,590)	277,487			5
6	Maintenance	94,375		93,067	187,442		187,442		187,442			6
7	Other (specify):*											7
8	**TOTAL General Services**	721,250	260,527	383,239	1,365,016		1,365,016	(3,644)	1,361,372			8
	B. Health Care and Programs											
9	Medical Director			11,200	11,200		11,200		11,200			9
10	Nursing and Medical Records	2,775,254	104,619	724	2,880,597		2,880,597		2,880,597			10
10a	Therapy			369,838	369,838		369,838		369,838			10a
11	Activities	120,521	3,758	6,528	130,807		130,807	(1,017)	129,790			11
12	Social Services	68,514		1,414	69,928		69,928		69,928			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,964,289	108,377	389,704	3,462,370		3,462,370	(1,017)	3,461,353			16
	C. General Administration											
17	Administrative	74,206		68,812	143,018		143,018		143,018			17
18	Directors Fees											18
19	Professional Services			65,114	65,114		65,114	(1,951)	63,163			19
20	Dues, Fees, Subscriptions & Promotions			27,117	27,117		27,117	(125)	26,992			20
21	Clerical & General Office Expenses	208,916	18,269	24,623	251,808		251,808	(4,982)	246,826			21
22	Employee Benefits & Payroll Taxes			818,897	818,897		818,897	(120)	818,777			22
23	Inservice Training & Education			190	190		190		190			23
24	Travel and Seminar			6,568	6,568		6,568		6,568			24
25	Other Admin. Staff Transportation			975	975		975		975			25
26	Insurance-Prop.Liab.Malpractice			130,999	130,999		130,999		130,999			26
27	Other (specify):*											27
28	**TOTAL General Administration**	283,122	18,269	1,143,295	1,444,686		1,444,686	(7,178)	1,437,508			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,968,661	387,173	1,916,238	6,272,072		6,272,072	(11,839)	6,260,233			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Monroe County Nursing Home #0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			293,280	293,280		293,280		293,280			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,136	38,136		38,136	(11,044)	27,092			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,197	5,197		5,197		5,197			35
36	Other (specify):* Alzheimer Acct Exp			1,478	1,478		1,478		1,478			36
37	TOTAL Ownership			338,091	338,091		338,091	(11,044)	327,047			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,658		62,658		62,658		62,658			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,308	115,308		115,308		115,308			42
43	Other (specify):* Nonallowable Costs			218,125	218,125		218,125	(218,125)				43
44	TOTAL Special Cost Centers		62,658	333,433	396,091		396,091	(218,125)	177,966			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,968,661	449,831	2,587,762	7,006,254		7,006,254	(241,008)	6,765,246			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,929)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,156)	43		28
29	Other-Attach Schedule See attached	(113,923)	var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (241,008)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (241,008)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe County Nursing Home
Provider # 0001628
11/30/03 **Schedule 5A**

Page 5: Line 29 - Other Disallowable Expenses

Description	Amount	Line Ref
Offset Interest Income against Interest Expense	(11,044)	32
Offset meal income against food	(1,552)	2
Out of period legal expenses	(1,951)	19
Disallow Day Care wages	(1,017)	11
Disallow Day Care Fica & IMRF	(120)	22
Disallow Day Care food	(502)	2
Disallow Day Care Utilities	(1,590)	5
Disallow Yellow Page advertising in telephone acct	(4,982)	21
Disallow Chamber of Commerce dues	(125)	20
Prior Year refund to State	(60,853)	43
Public relations expense	(4,042)	43
Advertising Facility Promotion	(13,603)	43
Bird Aviary	(1,370)	43
Medicare Lab/Xray	(10,663)	43
Other nonallowable expense	(509)	43
	(113,923)	

Monroe County Nursing Home

ID# 0001628

Report Period Beginning: 12/01/02

Ending: 11/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(127,085)	0	0	0	0	0	0	0	0	0	0	(127,085)	43
44	**TOTAL Special Cost Centers**	(127,085)	0	0	0	0	0	0	0	0	0	0	(127,085)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(127,085)	0	0	0	0	0	0	0	0	0	0	(127,085)	45

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V				N/A				7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Dale Haudrich	County Commissione	Administrative	0.00			<1%		$ None	N/A	1
2	Don Dietz	County Commissione	Administrative	0.00			<1%		None	N/A	2
3	Frank Kohler	County Commissione	Administrative	0.00			<1%		None	N/A	3
4											4
5											5
6											6
7	Note: No County Commissioner provided services to the nursing home during the reporting period. No business entity owned by a board member										7
8	conducted business transactions with the nursing home during the reporting period.										8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6		N/A								6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Nat'l Bank - Waterloo		X	Ventilation renovation	$5,589.00	03/01/98	$ 570,000	$	02/01/06	0.0535	$ 1,684	1
2	First Nat'l Bank - Waterloo		X	Renovation	$4,023.00	04/17/00	355,347	166,680	04/28/10	0.0600	14,152	2
3	First Nat'l Bank - Waterloo		X	Alzheimer renovation	$11,083.00	09/15/95	1,329,000	364,859	09/15/07	0.0535	22,300	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$20,695.00		$ 2,254,347	$ 531,539			$ 38,136	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(11,044)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,044)	14
15	TOTALS (line 9+line14)						$ 2,254,347	$ 531,539			$ 27,092	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

County facility does not pay real estate tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe County Nursing Home COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0001628

CONTACT PERSON REGARDING THIS REPORT Sandy Wiles, Business Office Manager

TELEPHONE (618) 939-3488 ext. 124 FAX #: (618) 939-5030

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	County facility does not pay real estate tax.		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.		N/A	$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? N/A YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,250 B. General Construction Type: Exterior Brick Frame Brick & Concrete Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	240,075	1949	$	1
2					2
3	TOTALS	240,075		$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1952	1952	$ 362,776	$	40	$	$	$ 362,776	4
5			1954	1954	155,296		40			155,296	5
6			1959	1959	464,584		40			464,584	6
7			1972	1972	1,262,811	31,570	40	31,570		999,722	7
8											8
	Improvement Type**										
9	Various Improvements			1979	223,119	5,578	40	5578		137,590	9
10	Various Improvements			1980	12,110	303	40	303		7,169	10
11	Various Improvements			1981	19,476	487	40	487		11,037	11
12	Various Improvements			1982	37,408	935	5-40	935		20,260	12
13	Various Improvements			1983	136,600	3,415	40	3415		70,577	13
14	Various Improvements			1984	242,178	12,109	5-20	12109		236,124	14
15	Various Improvements			1985	25,405	1,270	5-20	1270		23,456	15
16	Various Improvements			1987	66,614	1,318	8-20	1318		61,966	16
17	Various Improvements			1988	6,602		10			6,602	17
18	Various Improvements			1989	32,306	2,153	15	2153		31,220	18
19	Various Improvements			1990	96,200	3,815	5-20	3815		54,879	19
20	Various Improvements			1991	13,393	327	5-20	327		13,325	20
21	Kitchen/Dining Room Improvements			1991	62,884	3,144	20	3144		37,478	21
22	Elevator			1992	103,298	5,165	5-20	5165		59,398	22
23	New Duct Work			1992	4,000	200	5-20	200		2,300	23
24	Flooring			1992	4,200	210	5-20	210		2,415	24
25	Entry Way Improvements			1992	16,415	821	20	821		9,031	25
26	Other Various Improvements			1992	7,135	357	20	357		4,106	26
27	Entrance Addition			1993	521,219	26,453	20	26453		261,394	27
28	Elevator Installation			1993	44,480	2,224	20	2224		22,240	28
29	East Hallway Renovation			1994	41,176	2,059	20	2059		19,561	29
30	Second Floor Sprinkler			1994	29,312	1,466	20	1466		13,927	30
31	Boiler Room Repair			1994	2,732	182	15	182		1,729	31
32	Air-Handler Repair			1994	2,231	149	15	149		1,416	32
33	Electrical Work			1994	7,000	350	20	350		3,325	33
34	Various Improvements			1995	10,289	686	15	686		5,954	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various Improvements	1995	$ 20,355	$ 1,018	20	$ 1,018	$	$ 8,812	37
38	Alzheimers Dining/Activity Area	1996	1,208,699	60,435	20	60,435		453,263	38
39	Heat & A/C Project	1996	83,800	4,190	20	4,190		31,425	39
40	Architect Fees	1996	70,506	3,525	20	3,525		26,438	40
41	Additional Costs	1996	12,811	641	20	641		4,808	41
42	Garden Project	1996	14,350	957	15	957		7,178	42
43	Fire Panel Upgrade	1997	7,503	1,072	12	1,072		6,968	43
44	Heaters	1997	8,341	1,191	12	1,191		7,742	44
45	Insulated Glass	1997	6,580	940	12	940		6,110	45
46	Cabinet Drywall	1997	4,212	602	12	602		3,913	46
47	Sidewalk	1997	700	47	15	47		303	47
48	Generator	1997	41,462	5,923	12	5,923		38,530	48
49	Painting	1998	24,644	1,232	20	1,232		7,289	49
50	Elevator Motor/Feeders	1998	7,991	399	20	399		2,261	50
51	Flooring - East Wing	1998	1,328	66	20	66		352	51
52	Closet Doors	1998	2,342	117	20	117		595	52
53	Sinks & Faucets	1998	422	21	20	21		123	53
54	Cabinets - 2E & 3E	1998	1,191	60	20	60		350	54
55	Counter Tops	1998	883	44	20	44		253	55
56	Architect Fees	1998	51,048	2,552	20	2,552		14,036	56
57	East end closets	1998	3,465	173	20	173		952	57
58	IDPH bid review	1998	2,400	120	20	120		660	58
59	Drywall	1998	19,500	975	20	975		5,363	59
60	HVAC	1998	343	17	20	17		94	60
61	Fire sprinklers	1998	30,294	1,515	20	1,515		8,332	61
62	Water heater	1998	724	36	20	36		197	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,639,143	$ 194,614		$ 194,614	$	$ 3,737,204	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,639,143	$ 194,614		$ 194,614	$	$ 3,737,204	1
2	Painting	1998	746	37	20	37		204	2
3	Plastering	1998	11,709	585	20	585		3,217	3
4	Demolition, site work, asphalt, excavation	1998	33,920	1,696	20	1,696		9,328	4
5	Concrete, precast, flatwork, steel, carpentry	1998	74,300	3,715	20	3,715		20,433	5
6	Millwork, doors, roofing, sheetmetal, sealants	1998	18,960	948	20	948		5,214	6
7	Glass/glazing, drywall, painting/wall covering, flooring	1998	104,080	5,204	20	5,204		28,622	7
8	Toilet, fire protection, plumbing, HVAC, electrical	1998	271,827	13,593	20	13,593		74,761	8
9	Contingency, general, bonds, change orders, contractor's fee	1998	121,885	6,094	20	6,094		33,517	9
10	Painting	1999	31,380	1,177	20	1,177		6,669	10
11									11
12	Air system - east wing	2000	337,536	16,877	20	16,877		59,070	12
13	Painting	2000	4,913	246	20	246		759	13
14	Canopy	2000	6,160	308	20	308		1,078	14
15									15
16	Fire alarm	2001	4,797	240	20	240		500	16
17	Architectural inspection	2001	6,119	306	20	306		714	17
18									18
19									19
20	Window upgrades	2002	36,187	1,809	20	1,809		2,714	20
21									21
22	Waterproofing Coating	2003	5,447	136	20	136		136	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,709,109	$ 247,585		$ 247,585	$	$ 3,984,140	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 855,849	$ 39,305	$ 39,305	$	5-20	$ 783,545	71
72	Current Year Purchases	80,806	5,772	5,772		7	5,772	72
73	Fully Depreciated Assets	71,977					71,977	73
74								74
75	TOTALS	$ 1,008,632	$ 45,077	$ 45,077	$		$ 861,294	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1996 Ford Bus	1996	$ 42,892	$	$	$	5	$ 42,892	76
77	Resident Care	Van	2003	8,650	618	618		7	618	77
78										78
79										79
80	TOTALS			$ 51,542	$ 618	$ 618	$		$ 43,510	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,769,283	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 293,280	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 293,280	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,888,944	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	New facility-design &	$ 364,442	92
93	application phase		93
94			94
95		$ 364,442	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,197 Description: Copiers - 4437, Dishwasher - 760
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,169	$ 32,537	$	2,169	$ 32,537	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,209	18,128		1,209	18,128	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		20,619	309,284		20,619	309,284	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				61,810		61,810	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory therapy	39(2)					848		848	13
14	TOTAL			$	23,997	$ 359,949	$ 62,658	23,997	$ 422,607	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe County Nursing Home
Provider #: 0001628
12/01/02 to 11/30/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,597,654	$ 1,597,654	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,671)	1,162,261	1,162,261	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	46,564	46,564	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached	10,955	10,955	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,817,434	$ 2,817,434	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,709,109	6,709,109	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,060,174	1,060,174	16
17	Accumulated Depreciation (book methods)	(4,888,944)	(4,888,944)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction-in-progress	364,442	364,442	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,244,781	$ 3,244,781	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,062,215	$ 6,062,215	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,885	$ 212,885	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	344,002	344,002	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	223,386	223,386	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,349	24,349	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,026	17,026	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prepaid Senior Jubilee	266	266	36
37	See attached Schedule 17A	248,776	248,776	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,070,690	$ 1,070,690	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	531,539	531,539	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 531,539	$ 531,539	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,602,229	$ 1,602,229	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,459,986	$ 4,459,986	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,062,215	$ 6,062,215	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Monroe County Nursing Home
Facility ID: 0001628
11/30/03 **Schedule 17A**

Page 17: Line 9 - Other Current Assets

Description	Amount
Uniforms	(1)
IRA Reserve	6
Unearned Income	10,950
	10,955

Page 17: Line 37 - Other Current Liabilities

Description	Amount
Audit liability - IDPA	90,895
InterGovermental - Unearned Income	157,881
	248,776

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,474,555	1
2	Restatements (describe):		2
3	External Auditor Adjustments	155,329	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,629,884	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	830,102	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 830,102	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,459,986	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,485,790	1
2	Discounts and Allowances for all Levels	(559,003)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,926,787	3
	B. Ancillary Revenue		
4	Day Care	9,617	4
5	Other Care for Outpatients		5
6	Therapy	811,650	6
7	Oxygen	58,851	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 880,118	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,968	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,552	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,344	16
17	Sale of Drugs	130,499	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,340	19
20	Radiology and X-Ray	4,589	20
21	Other Medical Services	134,330	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 286,622	23
	D. Non-Operating Revenue		
24	Contributions	695,928	24
25	Interest and Other Investment Income***	11,044	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 706,972	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule 19A**	35,857	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,857	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,836,356	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,365,016	31
32	Health Care	3,462,370	32
33	General Administration	1,444,686	33
	B. Capital Expense		
34	Ownership	338,091	34
	C. Ancillary Expense		
35	Special Cost Centers	280,783	35
36	Provider Participation Fee	115,308	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,006,254	40
41	**Income before Income Taxes (line 30 minus line 40)****	830,102	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 830,102	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility files as part of County return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Monroe County Nursing Home
Provider #: 0001628
12/01/02 to 11/30/03

Schedule 19A

Line 28: Other Revenue

Rental of equipment	28,587
Transportation	1,920
Vending machine commission	5,259
Other	91
Total Line 27	35,857

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,732	2,080	$ 50,960	$ 24.50	1
2	Assistant Director of Nursing	1,836	2,120	43,544	20.54	2
3	Registered Nurses	3,813	4,456	88,213	19.80	3
4	Licensed Practical Nurses	49,644	54,255	888,516	16.38	4
5	Nurse Aides & Orderlies	127,203	132,536	1,410,180	10.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,629	4,659	57,101	12.26	8
9	Activity Director	3,823	4,289	50,911	11.87	9
10	Activity Assistants	6,476	6,817	69,610	10.21	10
11	Social Service Workers	4,349	5,045	68,514	13.58	11
12	Dietician					12
13	Food Service Supervisor	1,828	2,255	34,108	15.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,282	32,353	279,447	8.64	15
16	Dishwashers					16
17	Maintenance Workers	5,357	7,594	94,375	12.43	17
18	Housekeepers	27,201	29,982	209,818	7.00	18
19	Laundry	11,131	12,268	103,502	8.44	19
20	Administrator	1,960	2,080	74,206	35.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,814	16,631	208,916	12.56	24
25	Vocational Instruction	2,033	2,182	21,082	9.66	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,002	5,082	75,360	14.83	31
32	Other Health Ca See Sch. 20A	7,103	7,323	140,298	19.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	308,216	334,007	$ 3,968,661 *	$ 11.88	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	243	$ 11,095	1(3)	35
36	Medical Director	Monthly	8,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	7	184	10(3)	38
39	Pharmacist Consultant	Monthly	540	10(3)	39
40	Physical Therapy Consultant	90	5,425	10A(3)	40
41	Occupational Therapy Consultant	59	3,539	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	925	10A(3)	43
44	Activity Consultant	25	1,414	11(3)	44
45	Social Service Consultant	24	1,414	12(3)	45
46	Other(specify)				46
47	Sub-acute Medical Director	Monthly	2,400	9(3)	47
48					48
49	TOTAL (lines 35 - 48)	464	$ 35,736		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Monroe County Nursing Home
Provider #: 0001628
11/30/03

Schedule 20A

	Hours Worked	Hours Paid	Total Salaries Wages	Average Hourly Wage
Care Plan Coordinator	3,929	4,009	72,957	18.20
Staff Development-Class Instructor	1,194	1,234	20,791	16.85
Medicare Coordinator	1,980	2,080	46,550	22.38
Line 32 - Other Health Care	7,103	7,323	140,298	19.16

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Keckritz	Administrator	0%	$ 74,206
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,206

B. Administrative - Other

Description	Amount
Management Performance, Inc.	$ 68,812
TOTAL (agree to Schedule V, line 17, col. 3)	$ 68,812
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 23,394
Lashly & Baer	Legal	184
Crotzer,Ford & Schraeder	Legal	3,825
Altschuler,Melvoin & Glasser LLP	Accounting	6,762
ADP	Payroll	5,825
American Express Tax & Business	Accounting	4,809
Schorb, Schmersahl LLC	Accounting	20,315
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 65,114

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 151,953
Unemployment Compensation Insurance	3,205
FICA Taxes	292,194
Employee Health Insurance	183,890
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	159,765
Employee Retirement & Pension	9,744
Employee Morale	14,262
Employee Drug Testing	3,764
TOTAL (agree to Schedule V, line 22, col.8)	$ 818,777

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,220
Advertising: Employee Recruitment	10,676
Health Care Worker Background Check	
(Indicate # of checks performed 65)	780
Life Services Network of Illinois dues	6,870
County Nursing Home Assoc of Ill dues	1,470
Various dues & subscriptions	1,101
Less: Public Relations Expense	( )
Non-allowable advertising	(125)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,992

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	6,568
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,568

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe County Nursing Home
Provider #: 0001628
12/01/02 to 11/30/03

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	65,114
Disallowed legal	(1,951)
Total (agree to Schedule V, line 19, column 8)	63,163

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6								N/A					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/01/02 Ending: 11/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See attached $8340**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,074** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,308**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **See Schedule 23A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,552**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Schorb & Schmersahl, LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **County audit still in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Monroe County Nursing Home
Provider #: 0001628 **Schedule 23A**
12/01/02 to 11/30/03

Page 23 - Question 2
Nursing Home Association dues:

Life Services Network of Illinois	**6870**
County Nursing Home Assoc. of Illinois	**1470**
	8340

Page 23 - Question 14
The facility operates an Adult Day Care Center. All expenses are adjusted out of the cost report.

RECONCILIATION REPORT **Monroe County Nursing** **12:40 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-241,008	equal to	-241,008	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	27,092	equal to	27,092	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	293,280	equal to	293,280	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	5,197	equal to	5,197	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	369,838	equal to	369,838	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	62,658	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,365,016	equal to	1,365,016	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,462,370	equal to	3,462,370	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,444,686	equal to	1,444,686	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	338,091	equal to	338,091	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	280,783	equal to	280,783	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	115,308	equal to	115,308	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,577,855	equal to	2,775,254	-197,399	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	120,521	equal to	120,521	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	68,514	equal to	68,514	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	313,555	equal to	313,555	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	94,375	equal to	94,375	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	209,818	equal to	209,818	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	103,502	equal to	103,502	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	74,206	equal to	74,206	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	208,916	equal to	208,916	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,968,661	equal to	3,968,661	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,095	< or = to	11,095	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	8,800	< or = to	11,200	-2,400	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	724	< or = to	724	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,414	< or = to	6,528	-5,114	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,414	< or = to	1,414	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	74,206	equal to	74,206	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	68,812	equal to	68,812	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	65,114	equal to	65,114	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	818,777	equal to	818,777	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	26,992	equal to	26,992	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,568	equal to	6,568	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	115,308	equal to	115,308	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	-120	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,785	equal to	4,452	-667	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	531,539	equal to	531,539	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to		0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,709,109	equal to	6,709,109	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,060,174	equal to	1,060,174	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,888,944	equal to	4,888,944	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	4,459,986	equal to	4,459,986	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	830,102	equal to	830,102	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	6,062,215	equal to	6,062,215	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!! 11/04/05 12:40:11 PM

HSA Number	11	Name	Monroe County Nursing Home		
Cost report period	From:	12/01/02	To: 11/30/03	Base Number	335
If this is an ICF/DD 16 facility, enter a 1 in cell C		N			
Licensed bed days:	77,015	Occupancy:	58,018	Pct. of occupancy:	75.33%
Illinois Public Aid Support Rate		$			
Genl Services Salary/Wage:	721,250	Col 1, Line 8 ---Audit Adj:			
Genl Admin Salary/Wage	283,122	Col 1, Line 28 ---Audit Adj			
Total Salary Wage	3,968,661	Col 1, Line 44 ---Audit Adj			
Employee Benefits	818,777	Col 8, Line 22 ---Audit Adj			
Total General Services:	1,361,372	Col 8, Line 8 ---Audit Adj:			
Total General Admin	1,437,508	Col 8, Line 28 ---Audit Adj			

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$721,250
Divided by Total Wages (Column 1, Line 44	$3,968,661
General service wages as percent of total wages	18.1736%
Employee Benefits (Column 10, Line 22	$818,777
Allocation of Employee Benefits to General Services Costs	$148,801
Plus Total General Services (Column 10, Line 8	$1,361,372
New Total General Services Cost	$1,510,173

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$283,122
Divided by Total Wages (Column 1, Line 45	$3,968,661
General administration wages as a percent of total wages	7.1339%
Employee Benefits (Column 10, Line 22	$818,777
Allocation of Emplayee Benefits to General Admin. Cost	$58,411
Plus Total General Administration (Column 10, Line 2	$1,437,508
Minus Total Fringe (Column 10, Line 22	$818,777
New Total General Administration Cos	$677,142

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	23	divided by 2 =	11.5
Beginning Day + Ending Day	31	divided by 60.8 =	0.509868421
Beginning Year + Ending Year =	205	multiplied by 6 =	1230
Sum of the three lines			1242.009868
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			335

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$1,510,173	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$1,510,173

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$677,142	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$677,142
3 Total Updated Support Costs (1 + 2		$2,187,315

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cost

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $34.97

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$2,187,315
Total Patient Days (Cost Report	58,018
Support Costs per Diem	$37.70

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	77,015
Multiplied by	0.93
	71,624
Minus total Patient Days	58,018
	13,606
One-third of difference	4,535
Plus Total Patient Day	58,018
Adjusted Occupancy	62,553
Total Support Costs (Step II, C, 3, above	$2,187,315
Divided by Adjusted Occupany	62553
Support Costs Per Diem	$34.97

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$35.80
Minus Support Costs Per Diem	$34.97
Difference	$0.83
Multiply the Difference by	0.5
One-Half of the Difference	$0.41
Plus Support Costs Per Diem	$34.97
Support Rate if costs are between 35th and 75th percentile	35.38

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$35.80
Minus Support Costs Per Diem	$34.97
Difference	$0.83
Multiply the Difference by	0.5
One-Half of the Difference	$0.41
Compare one-half the difference to the profit ceiling for your HSA in Table II and	2.955
Enter the Lower of the Two Amounts	$0.410
Plus Support Costs Per Diem	$34.97
Support Rate if support costs less than 35th percentile	$35.38

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$35.38**

75th Percentile is	$35.80
35th Percentile is	$29.99

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/04/05 12:40:11 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Monroe County Nursing Home** ID: **0001628**

HSA No.: 11 Own or Rent? (O or R): ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	211	Total Patient Days	58,018
Begin	**12/01/02**	Licensed Bed Days:	77,015	% Occupied	75.33%
End	**11/30/03**			Capital Days	71,624

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1983
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	6709109
2. Total licensed beds from cost report Page 2, Line 7, column 3	211
3. Line 1 divided by Line 2	$31,797
4. Regional construction inflator from Table 2	1.57
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	49921
C. Obtain the Uniform Building Value from Table 1	18453
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	49921
2. Uniform building value from Line C	18453
3. Add Lines 1 and 2	68374
4. Divide by 2 to obtain average	34187
5. Enter 120% of line C	22144
6. The blended value is the lesser of Line 4 or Line 5	22144
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	65.3215
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	7.19
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	9.69
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0
J. Property Tax Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:	
1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	71,624
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	1.03527
5. Equals: Updated Property Tax Cost	0
Capital Days The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)	
1. Total Patient Days	58,018
2. Total Licensed Bed Days * .93	71624
3. Capital Days (higher of Line 1 or Line 2)	71,624
K. Total Capital Rate for FY 94	
1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	9.69
2. Add Property Tax from Line J5	0
3. Total capital rate (add Lines 1 & 2)	9.69

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page	Linked Page
1	1	52	362776	18864352	12	12
2	2	54	155296	8385984	12	12
3	3	59	464584	27410456	12	12
4	4	72	1262811	90922392	12	12
5	5	0	0	0	12	12
6	6	79	223119	17626401	12	12
7	7	80	12110	968800	12	12
8	8	81	19476	1577556	12	12
9	9	82	37408	3067456	12	12
10	10	83	136600	11337800	12	12
11	11	84	242178	20342952	12	12
12	12	85	25405	2159425	12	12
13	13	87	66614	5795418	12	12
14	14	88	6602	580976	12	12
15	15	89	32306	2875234	12	12
16	16	90	96200	8658000	12	12
17	17	91	13393	1218763	12	12
18	18	91	62884	5722444	12	12
19	19	92	103298	9503416	12	12
20	20	92	4000	368000	12	12
21	21	92	4200	386400	12	12
22	22	92	16415	1510180	12	12
23	23	92	7135	656420	12	12
24	24	93	521219	48473367	12	12
25	25	93	44480	4136640	12	12
26	26	94	41176	3870544	12	12
27	27	94	29312	2755328	12	12
28	28	94	2732	256808	12	12
29	29	94	2231	209714	12	12
30	30	94	7000	658000	12	12
31	31	95	10289	977455	12	12
32	32	0	0	0	12	12
33	33	0	0	0	12	12
34	34	95	20355	1933725	12A	12A
35	35	96	1208699	116035104	12A	12A
36	36	96	83800	8044800	12A	12A
37	37	96	70506	6768576	12A	12A
38	38	96	12811	1229856	12A	12A
39	39	96	14350	1377600	12A	12A
40	40	97	7503	727791	12A	12A
41	41	97	8341	809077	12A	12A
42	42	97	6580	638260	12A	12A
43	43	97	4212	408564	12A	12A
44	44	97	700	67900	12A	12A
45	45	97	41462	4021814	12A	12A
46	46	98	24644	2415112	12A	12A
47	47	98	7991	783118	12A	12A
48	48	98	1328	130144	12A	12A
49	49	98	2342	229516	12A	12A
50	50	98	422	41356	12A	12A
51	51	98	1191	116718	12A	12A
52	52	98	883	86534	12A	12A
53	53	98	51048	5002704	12A	12A
54	54	98	3465	339570	12A	12A
55	55	98	2400	235200	12A	12A
56	56	98	19500	1911000	12A	12A
57	57	98	343	33614	12A	12A
58	58	98	30294	2968812	12A	12A
59	59	98	724	70952	12A	12A
60	60	0	0	0	12A	12A
61	61	0	0	0	12A	12A
62	62	0	0	0	12A	12A
63	63	0	0	0	12A	12A
64	64	0	0	0	12A	12A
65	65	0	0	0	12A	12A
66	66	0	0	0	12A	12A
67	67	98	746	73108	12B	12B
68	68	98	11709	1147482	12B	12B
69	69	98	33920	3324160	12B	12B
70	70	98	74300	7281400	12B	12B
71	71	98	18960	1858080	12B	12B
72	72	98	104080	10199840	12B	12B
73	73	98	271827	26639046	12B	12B
74	74	98	121885	11944730	12B	12B
75	75	99	31380	3106620	12B	12B
76	76	0	0	0	12B	12B
77	77	100	337536	33753600	12B	12B
78	78	100	4913	491300	12B	12B
79	79	100	6160	616000	12B	12B
80	80	0	0	0	12B	12B
81	81	101	4797	484497	12B	12B
82	82	101	6119	618019	12B	12B
83	83	0	0	0	12B	12B
84	84	0	0	0	12B	12B
85	85	102	36187	3691074	12B	12B
86	86	0	0	0	12B	12B
87	87	103	5447	561041	12B	12B
88	88	0	0	0	12B	12B
89	89	0	0	0	12B	12B
90	90	0	0	0	12B	12B
91	91	0	0	0	12B	12B
92	92	0	0	0	12B	12B
93	93	0	0	0	12B	12B
94	94	0	0	0	12B	12B
95	95	0	0	0	12B	12B
96	96	0	0	0	12B	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

563494095 6709109 83.98940828

Base Year = 1983

TABLE 1 2

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 3

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	313,555	23,016	11,095	347,666	0	347,666	0	347,666
2. Food Purchase	0	191,074	0	191,074	0	191,074	-2,054	189,020
3. Housekeeping	209,818	26,177	0	235,995	0	235,995	0	235,995
4. Laundry	103,502	20,260	0	123,762	0	123,762	0	123,762
5. Heat and Other Utilities	0	0	279,077	279,077	0	279,077	-1,590	277,487
6. Maintenance	94,375	0	93,067	187,442	0	187,442	0	187,442
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	721,250	260,527	383,239	1,365,016	0	1,365,016	-3,644	1,361,372
9. Medical Director	0	0	11,200	11,200	0	11,200	0	11,200
10. Nursing & Medical Records	2,775,254	104,619	724	2,880,597	0	2,880,597	0	2,880,597
10a. Therapy	0	0	369,838	369,838	0	369,838	0	369,838
11. Activities	120,521	3,758	6,528	130,807	0	130,807	-1,017	129,790
12. Social Services	68,514	0	1,414	69,928	0	69,928	0	69,928
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,964,289	108,377	389,704	3,462,370	0	3,462,370	-1,017	3,461,353
17. Administrative	74,206	0	68,812	143,018	0	143,018	0	143,018
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	65,114	65,114	0	65,114	-1,951	63,163
20. Fees, Subscriptions & Promotion	0	0	27,117	27,117	0	27,117	-125	26,992
21. Clerical & General Office	208,916	18,269	24,623	251,808	0	251,808	-4,982	246,826
22. Employee Benefits & Payroll	0	0	818,897	818,897	0	818,897	-120	818,777
23. Inservice Training & Education	0	0	190	190	0	190	0	190
24. Travel and Seminar	0	0	6,568	6,568	0	6,568	0	6,568
25. Other Admin. Staff Trans	0	0	975	975	0	975	0	975
26. Insurance-Prop.Liab.Malpractice	0	0	130,999	130,999	0	130,999	0	130,999
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	283,122	18,269	1,143,295	1,444,686	0	1,444,686	-7,178	1,437,508
29. Total General Administrative	3,968,661	387,173	1,916,238	6,272,072	0	6,272,072	-11,839	6,260,233
30. Depreciation	0	0	293,280	293,280	0	293,280	0	293,280
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	38,136	38,136	0	38,136	-11,044	27,092
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	5,197	5,197	0	5,197	0	5,197
36. Other (specify):*	0	0	1,478	1,478	0	1,478	0	1,478
37. Total Ownership	0	0	338,091	338,091	0	338,091	-11,044	327,047
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	62,658	0	62,658	0	62,658	0	62,658
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	115,308	115,308	0	115,308	0	115,308
43. Other (specify):*	0	0	218,125	218,125	0	218,125	-218,125	0
44. Total Special Cost Ce	0	62,658	333,433	396,091	0	396,091	-218,125	177,966
45. Grand Total	3,968,661	449,831	2,587,762	7,006,254	0	7,006,254	-241,008	6,765,246

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,597,654	1,597,654
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,162,261	1,162,261
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	46,564	46,564
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	10,955	10,955
10. Total current assets	2,817,434	2,817,434
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	6,709,109	6,709,109
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,060,174	1,060,174
17. Accumulated Depreciation (book methods)	-4,888,944	-4,888,944
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	364,442	364,442
24. Total Long-Term Assets	3,244,781	3,244,781
25. Total Assets	6,062,215	6,062,215
CURRENT LIABILITIES		
26. Accounts Payable	212,885	212,885
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	344,002	344,002
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	223,386	223,386
31. Accrued Taxes Payable	24,349	24,349
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	17,026	17,026
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	266	266
37. Other Current Liabilities (specify):	248,776	248,776
38. Total Current Liabilities	1,070,690	1,070,690
LONG TERM LIABILITES		
39.Long-Term Notes Payable	531,539	531,539
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	531,539	531,539
46.Total Liabilities	1,602,229	1,602,229
47.Total Equity	4,459,986	4,459,986
48.Total Liabilities and Equity	6,062,215	6,062,215

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,485,790
2. Discounts and Allowances for all Levels	-559,003
Subtotal - Inpatient Care	5,926,787
4. Day Care	9,617
5. Other Care for Outpatients	0
6. Therapy	811,650
7. Oxygen	58,851
Subtotal - Anciliary Revenue	880,118
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	5,968
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,552
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	3,344
17. Sale of Drugs	130,499
18. Sale of Supplies to Non-Patients	0
19. Laboratory	6,340
20. Radiologyand X-Ray	4,589
21. Other Medical Services	134,330
22. Laundry	0
Subtotal - Other Operating Revenue	286,622
24. Contributions	695,928
25. Interest and Other Investments Income	11,044
Subtotal - Non-Operating Revenue	706,972
27. Other Revenue (specify):	35,857
28. Other Revenue (specify):	0
Subtotal - Other Revenue	35,857
30. Total Revenue	7,836,356
31. General Services	1,365,016
32. Health Care	3,462,370
33. General Administration	1,444,686
34. Ownership	338,091
35. Special Cost Centers	280,783
35. Provider Participation Fee	115,308
37. Other	0
40. Total Expenses	7,006,254
41. Income Before Income Taxes	830,102
42. Income Taxes	0
43. Net Income or Loss for the Year	830,102

Page	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	Provider Participation fee is linked from page 4